PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
17E613		B. WING _	B. WING		C 09/28/2015		
	ROVIDER OR SUPPLIER			615 P	ET ADDRESS, CITY, STATE, ZIP CODE PRICE AVE LEY, KS 67748	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	_	s represent the findings of n #90733 and #91553.					
	A revised copy of the provider on 9/30/15.	2567 was sent to the					
F 157 SS=D	483.10(b)(11) NOTIFY (INJURY/DECLINE/R		F 1	57			
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or						
		rd and periodically update e number of the resident's					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E613	B. WING		C 09/28/2015	
	ROVIDER OR SUPPLIER	1,2010		STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	09/26/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 157		e 1 or interested family member. I is not met as evidenced	F 1	57		
	by: The facility had a ce sample included 4 re observation, record r facility failed to notify	nsus of 37 residents. The sidents. Based on eview and interview the the physician the facility had ninistered medications for				
	- Resident #1's adm Set assessment, date resident had a (BIMS Status score of 5, wh had severe cognitive	ission (MDS) Minimum Data ed 8/5/15, indicated the b) Brief Interview for Mental iich indicated the resident impairment. The MDS t received antipsychotic and cations.				
	Seroquel (antipsycho Cymbalta (antidepres	icated the resident received stic medication) and serive medication). In indicated the resident and directed staff to				
	following medications Prednisone (anti-inflatially. Prilosec (decreases a produced), 20 mg, da	nister, to the resident, the s: ammatory), 5 (mg) milligram, amount of stomach acid				

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 3 7			(X3) DATE SURVEY COMPLETED		
		17E613	B. WING			C 09/28/2015		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		09/20/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 157	times daily. Maalox Max suspen milliliters, before me Review of the (MAR Record and nurse's documentation the redications betwee Prednisone, 5 mg, 7 days, 8 doses) Prilosec, 20 mg, 7/3 6 doses) Seroquel, 25 mg, 7/3 6 doses) Neurontin, 100 mg, afternoon. (5 days, Maalox suspension, at noon. (8 days, 30 on 9/16/15 at 7:30 A resident left the dinition and self-propelled froom. On 9/16/15 at 5:25 for verified staff had not ordered doses of Ne Seroquel, Maalox at MAR. He/she stated to use the medication forgetting to bring the Administrative Nurse obtain the medication failed to notify the registern medications.	sion (antacid), 5 (ml) als and at bedtime.) Medication Administration notes revealed no esident received the following n 7/31/15 and 8/7/15: /31/15 through 8/7/15. (8 days, 31/15 through 8/5/15. (6 days, 31/15 through 8/4/15 in the 14 doses) 5 ml, 7/31/15 through 8/4/15 in the 14 doses) AM, observation revealed the ng table, in his/her wheelchair om the dining room to his/her end the family wanted the facility ns supplied by them, but kept the medications to the facility. The end of the end of the stated staff failed to a timely manner and esident's physician the elived several doses of 5	F 15	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
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F 157	Continued From page	e 3	F 1	57			
	numerous doses of 5 the first week after th facility.	administered to the resident, different medications during e resident's admission to the					
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAN	(k)(2) RIGHT TO NING CARE-REVISE CP	F 2	80			
	incompetent or other incapacitated under t	he laws of the State, to g care and treatment or					
	within 7 days after the comprehensive asses interdisciplinary teams physician, a registere for the resident, and disciplines as determinand, to the extent practice the resident, the resident, the resident practice in the resident practice.	re plan must be developed e completion of the ssment; prepared by an a, that includes the attending ed nurse with responsibility other appropriate staff in sined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed m of qualified persons after					
	by: The facility had a ce sample included 4 re accidents. Based on and interview, the fac appropriate intervent	r is not met as evidenced nsus of 37 residents. The sidents reviewed for observation, record review cility failed to care plan ions to prevent further falls eviewed for accidents. (#1)					

NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		17E613 B.		B. WING _		_		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)					615 PRICE AVE	TE, ZIP CODE	09/20/2013	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORREC' CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIAT		
F 280 Continued From page 4 Findings included: - Resident #1's admission (MDS) Minimum Data Set assessment, dated 8/5/15, indicated the resident had adequate vision with glasses and a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident independent with bed mobility, transfers, walking, eating, dressing, required supervision with tolleting, and limited assistance with personal hygiene. The assessment indicated the resident's balance unstable, but he/she was able to stabilize self without assistance, had no (ROM) Range of Motion impairment, used a walker, had no history of falls prior to admission, and no falls since admission. The 8/5/15 (CAA) Care Area Assessment summary for falls indicated the resident at high risk for falls, used a walker, and attempted to carry beverages and manage his/her walker at the same time. The summary indicated the resident walked throughout the facility several times daily, and received Seroquel (an antipsychotic medication) and Cymbalta (an antidepressive medication) and cymbalta elade to gait, balance problems and poor safety awareness. The care plan directed staff to educate the resident about safety reminders, follow facility fall protocol, and evaluate and supply appropriate assistive devices. The 8/27/15 care plan update directed staff to ensure a safe environment including floor free of spills or clutter, adequate lighting, call light in reach, and bedt in	F 280	Findings included: Resident #1's admi Set assessment, date resident had adequate (BIMS) Brief Interview 5, which indicated the cognitive impairment. resident independent walking, eating, dress with toileting, and lim hygiene. The assessibalance unstable, but self without assistance Motion impairment, u of falls prior to admission. The 8/5/15 (CAA) Ca summary for falls indirisk for falls, used a warry beverages and the same time. The sresident walked throutimes daily, and receivantidepressive medical antidepressive medical antidepressive medical antidepressive medical antidepressive medical stated the resident at gait, balance problem awareness. The care educate the resident follow facility fall protessive plan update direct environment including	ession (MDS) Minimum Data ed 8/5/15, indicated the e vision with glasses and a v for Mental Status score of e resident had severe. The MDS indicated the with bed mobility, transfers, sing, required supervision ited assistance with personal ment indicated the resident's the/she was able to stabilize e, had no (ROM) Range of sed a walker, had no history sion, and no falls since. The Area Assessment cated the resident's the/she was able to stabilize e, had no (ROM) Range of sed a walker, had no history sion, and no falls since. The Area Assessment cated the resident at high valker, and attempted to manage his/her walker at ummary indicated the eighout the facility several ved Seroquel (antion) and Cymbalta (an ation). The since care plan for falls high risk for falls related to its and poor safety plan directed staff to about safety reminders, bool, and evaluate and esistive devices. The 8/27/15 cted staff to ensure a safe grillor free of spills or clutter,	F	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E613	B. WING	B. WING		C 09/28/2015	
	ROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE S15 PRICE AVE DAKLEY, KS 67748		
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F 280	checks, and check the of Motion. The Fall Risk assess following score guidel higher, moderate= 25 Review of the assess following scores for the resident: 7/30/15-55 8/6/15-70 The 8/4/15 (PT) Physindicated the resident frequently up, walking included restorative eand improve function living. The 8/6/15 (OT) Occus creen stated the resident walker in an ustated no alarms used a walker in an ustated no alarms used agitation and the resident had a "crash" a while skinned and bruised I reported he/she had a The 8/6/15 mobility as indicated no ROM immaintain standing bal balance not steady, by	wentions, neurological e resident's (ROM) Range ments indicated the lines: high risk= 45 and 6-44, low risk = 0-24). ments revealed the ne cognitively impaired sical Therapy assessment a high risk for falls and was go in the halls. The plan exercises to maintain status for (ADLs) activities of daily upational Therapy admission ident moved quickly and masfe manner. The screen do for the resident, due to dent was always on the go. The resident reported he/she ago, that resulted in a left finger. The resident a bad fall at home. Seessment by nursing pairment, moderate ability to ance and the resident's but he/she was able to	F	280	,		
	his/her head when try	115 stated the resident hit ving to get popcorn from the I was not using his/her					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 280	fell backwards and h. The fall report stated the fall, called for a n room, where the fall investigation indicate large bruise to the bableeding noted, along his/her right 2nd finge provided wound care finger wound. After the performed active RO to a chair and remind severe cognitive impowalker and ask for her sident had no chan his/her neurological stated the resident and was unsteady, and the resident to slow down. The 8/19/15 care plastated the resident in grooming, toileting an note stated the period to show the stated the resident in grooming, toileting an note stated the period to show the stated the resident in grooming, toileting an note stated the resident in grooming to show the stated the resident in grooming to show the stated the resident in groomi	the report stated the resident it his/her head on the floor. The housekeeper, who saw urse to come to the dining had occurred. The d the resident sustained a tack of his/her head, with little g with a 2 x 2 skin tear to the resident denied any pain, M, the staff assisted him/her led the resident (who had airment) to use his/her lelp if needed. M, nurse's note indicated the tages in mental status and lestatus was intact. The note mbulated with a walker, but the staff encourage the had. In conference meeting note dependent with dressing, and personal hygiene. The lent independently ambulated a risk for falls, fell on 8/6/15, The note stated staff the resident's walker to cup in, and encouraged walker with him/her at all PM, nurse's note stated the le call from the hospital staff, an had diagnosed the le, subdural hematoma from	F 28			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		17E613	B. WING		09/28/2015	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	1 03/20/2010	
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F 280	Continued From pag	ge 7	F 280			
	The 9/1/15 re-admis	ssion fall risk indicated high 105.				
	indicated the resider moderate ability to n	assessment, by nursing, nt had no ROM impairment, naintain standing balance, not steady but able to istance.				
	housekeeper E obse from his/her wheelch his/her head on the housekeeper stated ambulating without a the resident could no was doing prior to the noted no injury at the	nurse's note indicated erved the resident ambulate hair to his/her bed, fall and hit floor. The note stated the the resident was up, assistance. The note stated of remember what he/she he fall, denied pain, and staff is time, and put alarms in of the resident's movements.				
	staff notified the phy and declining blood at 8:30 AM the resid 89/60 (optimal range blood pressure was	AM, nurse's note indicated resician of the resident's fall pressures. The note indicated lent's blood pressure was e is 110/70) and at 9:00 AM 70/55. The physician directed resident and encourage fluids.				
	the resident complai but was unable to de The note indicated t and stated " I think I noted the resident v appointment with his	AM, nurse's note indicated ined of his/her head hurting, escribe or rate his/her pain. he resident refused Tylenol need to see the doctor". Staff ery pale, and made an s/her physician for 11:30 AM.				

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	ROVIDER OR SUPPLIER OUNTY MANOR - LTCU	1		STREET ADD 615 PRICE A OAKLEY, K		1 09/	20/2015
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F 280	maintenance person disabled the alarm, the dining room. Obsassisted the resident sat with him/her while On 9/16/15 at 7:30 Al resident left the dining wheelchair, and self-proom to his/her room revealed the resident hand and a cup of costaff came in to offer stayed to assist. The staff to use the gait be his/her walker to stan recliner. The resident unsteadiness, reacher liner arms to let hichair. The staff actival leaving the room. On 9/15/15 at 2:55 Ple he/she fell when atterwithout assistance. Hot use the call light vencourage him/her to was independent mostated he/she had fall to worse, and the staff Emergency Room. On 9/15/15 at 4:10 Ple resident's initial care completed and the collacked individualized further falls.	and stated the resident then walked independently to ervation revealed staff to get a beverage, and then the he/she did an activity. M, observation revealed the g table, in his/her propelled from the dining the Further observation held a box of tissues in one ffee in the other hand. Two the resident help and 1 resident refused to allow the transfer, used d and turn in front of the the stood tall with minimal the dback and used the m/herself down into the the the chair alarm before M, the resident reported mpting to sit in the recliner the/she stated he/she does the resident stated he/she the to the time. The resident then before, but this fall hurt a the took him/her to the (ER)	F2	280			

' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E613	B. WING		C 09/28/2015		
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F 280	resident was getting. Housekeeping Staff I standing on a little string in the area, lost his/h his/her hand/arm on On 9/16/15 at 2:00 P stated he/she was in asked for some pape Housekeeping Staff I resident's walker fall him/her on the floor, recliner. Housekeepin had been up walking On 9/16/15 at 2:14 P resident was unstead got up without assistaday, and ambulated this/her walker. On 9/16/15 at 2:40 P resident's falls are us stated staff placed all resident figured out h Nurse Aide B stated staff placed all resident figured out in directly to the pager salarm did not sound in directly to the pager salarm did not sound the staff found the On 9/16/15 at 3:00 P resident was independently and are and the staff found the on 9/16/15 at 3:00 P resident was very unwheelchair for mobility.	the dining room when the some popcorn on 8/6/15. I stated the resident was ep stool, with no nursing staff er balance and fell, hitting the refrigerator. M, Housekeeping Staff E the hall when the resident	F 280				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED	
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F 280	On 9/16/15 at 5:25 PI verified the resident's individualized interveron the initial and com to and after the resident. The facility's 8/7/15 F	n without calling for help. M, Administrative Nurse D care plan lacked ntions for prevention of falls, prehensive care plans, prior	F 28	50		
	completed on admiss significant change an interventions deemed to minimize injuries. It be needed are to be possible to protect the coordinator will updat stated the care plan v fall, and updated as n be reviewed for possi	ion, quarterly, with a d with each fall and l appropriate put into place interventions determined to out in place as soon as e resident. The MDS e the care plan. The policy would be reviewed with each leeded. Accident/falls are to				
F 281 SS=D	Resident #1, who fell on 8/6/15, and fell ag	ntions to prevent falls for and sustained a head injury ain on 9/14/15. ICES PROVIDED MEET	F 28	31		
		d or arranged by the facility all standards of quality.				
	by:	is not met as evidenced nsus of 37 residents. The sidents reviewed for				

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F 281	and interview, the fa interventions on the a newly admitted rest Findings included: - The 7/30/15 initial resident cognitively in wears glasses, and mobility and toileting transfers, ambulation plan stated the reside for ambulation or lock what type of assistive any other fall prevention. The 7/30/15 nursing indicated the resider time, and had normal assessment indicate confused, had normal independent with be required assistance dressing, toileting and The 7/30/15 Fall Rist the resident at high in the same and the sam	care plan to prevent falls for sident. (#1) care plan indicated the mpaired, visually impaired, required assistance with h, but independent with h, and locomotion. The care ent used an assistive device comotion, but failed to identify e device the resident used or tion interventions. admission assessment ht alert to person, place and al, but unsteady gait. The d the resident was calm, al (ROM) range of motion, d mobility, transfers, eating, with walking, locomotion,	F 2	,		
	his/her head when to popcorn machine, and walker at the time. The fell backwards, hit his the housekeeper, who nurse to come to the	5/15 stated the resident hit ying to get popcorn from the nd was not using his/her he report stated the resident s/her head on the floor and no saw the fall, called for a edining room where the fall eport indicated the resident				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING		COMPLETED		
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F 281	head, with little blee skin tear to his/her rindicated after the reperformed active RC to a chair and remin severe cognitive impossible walker and ask for his one of the complete for room. Further obseried a box of tissues coffee in the other his revealed two staff can help and 1 stayed to allow staff to use used his/her walker the recliner. The resunsteadiness, reach recliner arms to let his chair. The staff activities and the completed and the clacked individualized further falls. On 9/16/15 at 5:25 Invertigation on the initial care plant.	uise to the back of his/her ding noted, along with a 2 x 2 ight 2nd finger. The report esident denied any pain and DM, the staff assisted him/her ded the resident (who had pairment) to use his/her delp if needed. AM, observation revealed the note that it is in one hand and a cup of and. Further observation ame in to offer the resident of assist. The resident refused the gait belt for the transfer, to stand and turn in front of dident stood tall with minimal and back, and used the minimilar delp and interventions to prevent delpth interventions to prevent PM, Nurse G verified the explan had not been comprehensive care plan delpth interventions to prevent PM, Administrative Nurse D is care plan lacked entions for prevention of falls	F 281		

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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		17E613	B. WING				28/2015
	ROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PRICE AVE DAKLEY, KS 67748	1 00.	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	to minimize injuries. I be needed are to be possible to protect the directed the MDS cooplan. The policy state reviewed with each fand accident/falls are alternative safety meand director of nursin. The facility failed to pinterventions on the infalls for Resident #1, and fell and sustained admission to the facil 483.25(h) FREE OF AHAZARDS/SUPERVITHE facility must ensurenvironment remains as is possible; and each	d with each fall, with appropriate put into place interventions determined to put in place as soon as a resident. The policy ordinator to update the care id the care plan would be all and updated as needed, to be reviewed for possible asures by the risk manager ig. Trovide individualized initial care plan to prevent who was a high risk for falls if a head injury 1 week after ity. ACCIDENT SION/DEVICES The policy ordinator in prevent who was a high risk for falls if a head injury 1 week after ity. ACCIDENT SION/DEVICES		323			
	by: The facility had a cer sample included 4 resaccidents. Based on record review the faci supervision and assis accidents for 2 of 4 seconds.	observation, interview and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		COMP	(X3) DATE SURVEY COMPLETED C			
		17E613	B. WING		ı	28/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	1 03/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Findings included: Resident #2's ann Set assessment, data resident's vision ader (BIMS) Brief Interviews, which indicated main impairment. The MD experienced hallucin are not really there.) and was independent daily living. The MDS no (ROM) range of munsteady balance, but he/she used a cane. since the prior MDS antipsychotic and an The 5/31/15 (CAA) Commary for falls stasside rail to independent his/her bed, used a crailing in the hallway. The 6/17/15 care platesident at high risk fensure the call light in resident to use it, and safety. The care platesident as sets and safety. The care platesident in the safety.	ual (MDS) Minimum Data ed 5/31/15, indicated the quate and he/she had a w for Mental Status score of	F 32	,		
	care plan revealed no cognitively impaired complained of knee p the following updates 8/29/15 -bed alarm in	nd treatment as ordered. The previsions after the resident fell on 6/23/15, and pain. The care plan revealed at 7/21/15 -15 minute checks, nitiated, 9/14/15 - The pain 15 minute bed checks and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E613	B. WING			1	28/2015
	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PRICE AVE DAKLEY, KS 67748	1 03/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	higher, moderate= 25 Review of the assess following scores for the resident: 5/31/15 30 6/23/15 70 7/20/15 80 8/29/15 90 8/31/15 90 9/11/15 90 The 6/12/15 mobility a indicated the resident stabilize self. The 8/20/15 PT asses used a quad cane, wa risk for falls. The asser used a quad cane, wa risk for falls. The asser used a function of the participate in group ex Review of the medical resident had falls on 6 9/10/15 and 9/11/15. The 9/3/15 (OT) Occu stated the resident fel chin. The resident stat the edge of his/her be assessment indicated resident about using a refused. The therapis alarms on the resident	enents indicated the ines: high risk= 45 and -44, low risk = 0-24). In the ments revealed the recognitively impaired assessment for balance not steady, but able to assess the resident as up as desired, and at high resident indicated the reticipate in therapy and arrage the resident to kercises.	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E613	B. WING			C 00/28/2045
	ROVIDER OR SUPPLIER OUNTY MANOR - LTCU	1.20.0		STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	ı	09/28/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	The 9/10/15 at 9:00 A housekeeping staff for in his/her room. The stated he/she was "guthe girls", and "there. The resident's cane would or complaints on notified the resident's The 9/11/15 at 8:58 A the resident was upsego outside to "get the come and pick them. Review of the medical interventions initiated "upset" resident. The 9/11/15 at 11:45 later) nurse's note stand fall to the right as bed, fell and bumped The note stated the rein his/her right groin at taking a step and whe resident to bend his/her right to the resident to bend his/her.	AM, nurse's note indicated bund the resident on the floor note indicated the resident oing to the kitchen to help is a slick spot on the floor". It was by his/her bed, no injury of pain voiced, and staff is physician and family. AM, nurse's note indicated et because he/she could not be boys before the police up". AI record revealed no by the staff to assist the AM, (2 hours, 47 minutes ated a (CNA) Certified Nurse esident lose his/her balance is he/she stood up from the his/her head on the wall. esident complained of pain area upon standing and with en the nurse asked the ner knee. The note stated the	F 32	3		
	medication, but facial was having pain. The staff obtained a physiand the facility transphospital for x-rays. The 2:15 PM, the nurse rehad a right hip fracture.	when asked, refused pain grimacing indicated he/she nurse's notes indicated the ician's order to obtain x-rays ported the resident to the ne notes further indicated, at eccived a report the resident re.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED			
		17E613	B. WING			C 28/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	1 09/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	checked the resident 11:45 AM. On 9/16/15 at 2:14 President is at high ris his/her cane at times facility, and "looks for Nurse A stated the rehis/her room by him/9/11/15, while being stated the resident "treomplained of pain in sent the resident to the complained of pain in sent the resident to the complained of pain in sent the resident to the complained of pain in sent the resident to the complained of pain in sent the resident to the complained of pain in sent the resident to the complained of pain in sent the resident attempted to safety awareness, and delusions. He/she state cane, and had an of steady. Nurse Aide Elassistance. On 9/16/15 at 3:00 President ambulated in cane. Nurse C stated hospital, staff walked resident got his/her stendent got his/her stendent was becomin walking and had more stated each fall seem "the children or family the resident away from On 9/16/15 at 5:25 President staff documents and provided controlled."	M, Nurse A stated the k for falls and forgets to use, ambulated all over the r little kids he/she has seen". It is ident fell on 9/10/15 in herself, and again on assisted by staff. Nurse A ripped over his/her feet" and in his/her right groin so staff he hospital for x-rays. M, Nurse Aide B stated the be independent, lacked and hallucinations and atted the resident walked with add gait, but was fairly is stated the resident refused M, Nurse C stated the independently with a quad after the resident was in the with him/her until the trength back. Nurse C stated with him/her until the trength back. Nurse C stated the ing more unstable with the hallucinations. Nurse C need to be related to finding y" and it was hard to re-orient	F 32	3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3	(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	,	03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	resident had hallucin times and one fall or was looking under hi Administrative Nurse have a policy related He/She stated the rerelated to a fall, with Administrative Nurse checks in the hour policy stated a fall riscompleted on admissignificant change an interventions deeme to minimize injuries. to be completed with possible causes. Interventions in the recommunicate to the report sheet. The MI care plan. The policy reviewed with each faccident/falls are to alternative safety me and DON. The facility failed to prove the resident #2, with checks as care plant.	ve Nurse D stated the rations that upset him/her at curred when the resident s/her bed "for the children". D stated the facility did not to visual or safety checks. It is ident was still in the hospital hip fracture, on 9/11/15. D verified the lack of visual rior to the resident's fall. Falls and Fall Prevention sk assessment form will be sion, quarterly, with a nd with each fall with d appropriate put into place. The Post Fall assessment is any witness information for erventions determined to be at in place as soon as possible int. Document the nurse's notes and next shift by the 24 hour DS coordinator will update the vistated the care plan is all and updated as needed. The possible reviewed for possible resurres by the risk manager. Drovide adequate supervision documentation of 15 minute ned. Resident #2 fell and while staff were in the room,	F3	23			
		ng admission assessment for d the resident alert to person,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING DEPOSITE OF THE PROVIDER OF THE		` ′	OMPLETED			
		17E613	B. WING			09/28/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	gait. The assessmer calm, confused, had movement, independent ransfers, and eating walking, locomotion, a walker. Resident #1's admisset assessment, dairesident had adequa (BIMS) Brief Interviets indicated the residimpairment. The Mindependent with be eating, dressing, rectoileting, and limited hygiene. The assess had unstable balances self without assistant used a walker, had a admission, and no family mand antidepressive in Physical Therapy. The 8/5/15 (CAA) Condicated the resident and used a walker. Carry beverages and the same time. The resident walked throat times daily, and recemedication) and Cymedication).	had normal, but unsteady not indicated the resident was a normal (ROM) range of dent with bed mobility, g; required assistance with a dressing, toileting and used sision (MDS) Minimum Data ted 8/5/15, indicated the ate vision with glasses and a sw for Mental Status score of tent had severe cognitive as indicated the resident was ad mobility, transfers, walking, quired supervision with assistance with personal sment indicated the resident see, but was able to stabilize the put was able to stabilize the had no ROM impairment, no history of falls prior to alls since admission. The resident received antipsychotic medications, and (PT) are Area Assessment for falls are Area Assessment for falls and the was at high risk for falls. The resident attempted to dismange his/her walker at summary indicated the sughout the facility several evived Seroquel (antipsychotic mbalta (antidepressive).	F 32			
	was cognitively impa	aired, visually impaired, wore assistance with mobility				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E613	B. WING			C	
	ROVIDER OR SUPPLIER OUNTY MANOR - LTCU	1, 2010		STREET ADDRESS, CITY, STATE, ZIP CO 615 PRICE AVE OAKLEY, KS 67748		99/28/2015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	transfers, ambulation plan stated the reside for ambulation or lock what type of assistive. The 8/7/15 compreheresident at high risk for balance problems and The care plan directed cognitively impaired in reminders, follow face evaluate and supply devices. The 8/27/15 staff to ensure a safe floor free of spills or of light in reach, and be the 9/14/15 update of interventions on the achecks, and check R. The Fall Risk assess 8/6/15, indicated the falls. The 8/4/15 (PT) Physindicated the resident frequently up, walking included restorative and improve function living. The 8/6/15 (OT) Occ.	eident was independent with a, and locomotion. The care cent used an assistive device comotion, but failed to identify device. The ensive care plan stated the for falls related to gait, ad poor safety awareness. The estate of	F 3				
	used a walker in an u stated no alarms use resident always on th resident reported he/	unsafe manner. The screen and due to agitation and the alle go. The screen stated the askinned and bruised left					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	: :	00/20/2010	
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F 323	Continued From pag	e 21 eported he/she had a bad	F3	23			
	fall at home. The 8/6/15 mobility a indicated no ROM immaintain standing ba balance was not steastabilize without assi The fall investigation fell and hit his/her he popcorn from the popusing his/her walker the resident fell back on the floor in the dirindicated the resident he back of his/her hoted, along with a 2 2nd finger. The report wound care on the rewound. After the resident performed active RO to a chair and remind severe cognitive impurals.	assessment by nursing apairment, moderate ability to lance and the resident's ady, but he/she able to stance. on 8/6/15 stated the resident ad when trying to get ocorn machine and was not at the time. The report stated wards and hit his/her head using room. The investigation to sustained a large bruise to ead, with little bleeding by 2 skin tear to his/her right art indicated staff provided esident's head and finger dent denied any pain and M, the staff assisted him/her led the resident (who had airment) to use his/her					
	resident had no char neurological status w the resident ambulate unsteady, and the state slow down. The note limitations but chose The 8/19/15 at 5:49 If staff called the nurse the resident was unreated to the left side with h	rges in mental status and ras intact. The note stated ed with a walker, but was aff encourage the resident to stated the resident knew					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E613	B. WING	 		C 09/28/2015	
	ROVIDER OR SUPPLIER OUNTY MANOR - LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	'		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	and regular. The note appeared unresponsi rubbing on the chest The 8/19/15 at 5:55 F the resident opened it transferred the reside wheelchair. The note speech was short and transferred him/her to accompanied the resident when after his/her appoint didn't look good and I The 8/19/15 radiology subdural hematomas the skull) could be active sub-acute (recent one of the stated the resident was dressing, grooming, the stated the resident was dressing, grooming, the stated staff obtained by the stated by the stated staff obtained by the stated staff obtained by the stated	retic (sweating), pulse weak indicated the resident ve to a sternal rub (hard over the heart). PM, nurse's note indicated his/her eyes and the staff int from a chair to a indicated the resident's di unclear. At 6:00 PM, staff in the facility van and a nurse dent to the hospital. At 6:17 di the resident's family the resident left the clinic, ment this afternoon, he/she his/her color wasn't right. Preport stated small (bruising on the brain under ute (very sudden) or early set). In conference meeting note as independent with oileting and personal sted the resident ambulated walker, was a high risk for 5 and hit his/her head. The lace his/her coffee cup in her to keep the walker with	F 32	23			

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E613	B. WING				28/2015	
	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PRICE AVE DAKLEY, KS 67748	1 031	20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	risk. The 9/9/15 mobility as indicated the resident moderate ability to ma and his/her balance we resident was able to so the sident was up and a sassistance. The note remember what he/sh and staff put alarms in the 9/14/15 at 9:37 A staff notified the physicand declining blood producated at 8:30 the swas 89/60 (optimal rate) AM blood pressure we stated to monitor the fluids. The 9/14/15 at 9:49 A the resident complain but was unable to des The note indicated the and stated "I think I moted the resident verappointment with his/sident and stated to the sident verappointment with his/sident and stated the sident verappointment with his/sident and sident and stated the sident verappointment with his/sident and stated the sident verappointment with his/sident and sident and sident and stated the sident and stated the sident and stated the sident and si	seessment, by nursing, had no ROM impairment, aintain standing balance, was not steady but the stabilize without assistance. series's note indicated rived the resident ambulate air to his/her bed and saw iit his/her head on the floor. Ousekeeper stated the ambulating without stated the resident could not be was doing prior to the fall, in place. MM, nurse's note indicated ician of the resident's fall ressures. The note resident's blood pressure ange is 110/70) and at 9:00 as 70/55. The physician resident and encourage MM, nurse's note indicated and ed of his/her head hurting, scribe or rate his/her pain. The resident refused Tylenol are do see the doctor. Staff ry pale and made an her physician for 11:30 AM.	F	323				
	facility received the x-	M nurse's note stated the ray report of the right hip e resident's fall on 9/14/15,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E613	B. WING			C 09/28/2015	
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		<u> </u>	09/28/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	and the report indicate hip and no definite according and no definite according and no definite according and to the resident state with him/her while on 9/16/15 at 7:30 A resident left the dininal and self-propelled from Further observed held a box of tissues coffee in the other has offer the resident help resident refused to all for the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the state of the self-propelled from the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the self-propelled from the transfer and unturn in front of the receivith minimal unstead used the recliner arm into the chair. The state of the received from the self-propelled fro	M, observation revealed staff is alarm box to the and stated the resident shut then walked independently bservation revealed staff to get a beverage, and then is he/she did an activity. M, observation revealed the grable, in his/her wheelchair im the dining room to his/her ation revealed the resident in one hand and a cup of ind. Two staff came in to or and 1 stayed to assist. The low staff to use the gait belt sed the walker to stand and cliner. The resident stood tall iness and reached back and is to let him/herself down aff activated the chair alarm form. M, the resident reported mpting to sit in the recliner le/she stated he/she does very much, even though staff to. The resident stated he/she st of the time. The resident len before, but this fall hurt a ff took him/her to the (ER) check for broken ribs. M, Nurse G verified the	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	C (X3) DATE SURVEY	
		17E613	B. WING		09/28/2015	
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		09/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	further falls. On 9/16/15 at 11:30 astated he/she was in resident was getting Housekeeping Staff I standing on a "little staff in the area, lost hitting his/her head on hand/arm on the refrion on 9/16/15 at 2:00 P stated he/she was in asked for some paper Housekeeping Staff I resident's walker fall him/her on the floor, recliner. Housekeeping had been up walking on 9/16/15 at 2:14 P resident was unstead got up without assistand ambulated throu walker. On 9/16/15 at 2:40 P staff placed alarms of figured out how to turn as stated staff had pla sound in the resident the pager system. He not sound when the rand ambulated to the found the alarm turner on 9/16/15 at 3:00 P	AM, Housekeeping Staff H the dining room when the some popcorn on 8/6/15. I stated the resident was tep stool", with no nursing his/her balance and fell, in the floor and his/her igerator. M, Housekeeping Staff E the hall when the resident er towels on 9/14/14. E stated he/she heard the and turned in time to see between bed one and his/her ing Staff E stated the resident without his/her walker. M, Nurse A stated the dy at times prior to the falls, ance a lot throughout the day ghout the facility with his/her M, Nurse Aide B stated after in him/her, the resident on the alarms off. Nurse Aide aced an alarm that did not c's room, but went directly to exishe stated the alarm did resident got up independently et dining room, and the staff	F 323			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BUI		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		03/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	was very unsteady no mobility. Nurse C star any mental changes 8/19 syncope (fainting the resident's memorattempted transfers of for help. On 9/16/15 at 5:25 P verified the resident's individualized intervers on the initial and composed to and after the resident's individualized intervers on the initial and composed to any force of nursing off reported staff moved dining room after the substantial planting room after the policy stated staff wo assessment form on significant change an interventions deemed to minimize injuries. If the possible to protect the coordinator will upday stated the care planting fall and updated as in the reviewed for possible room and the planting room after the possible to protect the coordinator will upday stated the care planting fall and updated as in the reviewed for possible to protect the coordinator planting room after the possible to protect the coordinator will upday stated the care planting room after the possible to protect the coordinator will upday stated the care planting room after the possible to protect the coordinator will upday stated the care planting room after the resident's protect	He/she stated the resident ow and used a wheelchair for ted he/she had not observed between the 8/7 fall and the g) episode. Nurse C stated y was poor and he/she on his/her own without calling. M, Administrative Nurse D is care plan lacked intions for prevention of falls in a prehensive care plans prior ent's falls. Observation at e "step stool", a 2 foot by 2 inform, under a desk in the fice. Administrative Nurse D the platform out of the resident's fall. Falls and Fall Prevention uld complete a fall risk admission, quarterly, with a land with each fall with disappropriate put into place interventions determined to put in place as soon as	F3				
	The facility failed to p interventions to preve fell and sustained a h	provide individualized ent falls for Resident #1, who nead injury 1 week after to the facility and fell again					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748		09/20/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Continued From page on 9/14/15.	e 27	F 3	23			
F 425 SS=D			F4	25			
	drugs and biologicals them under an agree §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licen A facility must provide (including procedures acquiring, receiving, administering of all dithe needs of each resulted to the facility must empalicensed pharmacis	rt. The facility may permit I to administer drugs if State under the general sed nurse. e pharmaceutical services is that assure the accurate dispensing, and rugs and biologicals) to meet sident. eloy or obtain the services of it who provides consultation provision of pharmacy					
	by: The facility had a cer sample included 4 res observation, record re facility failed to obtain medications in a time sampled residents. (#	eview and interview the n physician ordered ly manner for 1 of 4					
	Findings included:						
	- Resident #1's admi	ssion (MDS) Minimum Data					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
NAME OF PROVIDER OR SUPPLIER LOGAN COUNTY MANOR - LTCU				STREET ADDRESS, CITY, STATE, ZIP O 615 PRICE AVE OAKLEY, KS 67748	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 425	resident had a (BIMS Status score of 5, wh	e 28 ed 8/5/15, indicated the) Brief Interview for Mental ich indicated the resident impairment. The MDS	F4	425			
		t received antipsychotic and ations. re Area Assessment ne resident received					
	Cymbalta (antidepres	ssive medication). In directed staff to administer					
	administer, to the res medications: Prednisone (anti-infla daily. Prilosec (decreases a produced), 20 mg, da Seroquel (antipsycho	ammatory), 5 (mg) milligram, amount of stomach acid hilly. htic), 25 mg, at bedtime. h used for nerve pain), three hion (antacid), 5 (ml)					
	Record and nurse's ridocumentation the remedications between Prednisone, 5 mg, 7/3 days, 8 doses) Prilosec, 20 mg, 7/31 6 doses) Seroquel, 25 mg, 7/3 5 doses)	sident received the following					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		17E613	B. WING _			C 09/28/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 PRICE AVE OAKLEY, KS 67748	<u> </u>	03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	afternoon. (5 days, 1-Maalox suspension, 9 at noon. (8 days, 30 dono). On 9/16/15 at 7:30 A resident left the dininand self-propelled from room. On 9/16/15 at 5:25 P verified staff had not ordered doses of Net Seroquel, Maalox and MAR. He/she stated to use the medication forgetting to bring the Administrative Nurse obtain the medication. The facility failed to comedications for administration for administrat	4 doses) 5 ml, 7/31/15 through 8/7/15 doses) M, observation revealed the g table, in his/her wheelchair m the dining room to his/her M, Administrative Nurse D administered the physician urontin, Prednisone, d Prilosec, as noted on the the family wanted the facility is supplied by them, but kept is medications to the facility. D stated staff failed to	F4	125			